

MaxorPlus Over-the-Counter (OTC), At-Home COVID Test Reimbursement Form

YOUR CLAIM CANNOT BE PROCESSED IF THIS FORM IS INCOMPLETE.

Patient Name First Middle Last	Plan Member Name						
Plan Member ID Number Patient Code Group Number of Birth mm dd ywy Patient: Sex M F Gurde One) Plan Member Address Street City State Zip Employer Name Insurance Company I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the OTC, at-home COVID-19 test(s) described hereon and authorize release of all information contained on this voucher to MaxorPlus and the underwriter. I agree that any benefits payable hereunder for OTC, at-home COVID-19 test(s) there or a signment of benefits hereunder. I certify that the OTC, at home COVID-19 test(s) that I am submixing for reimbursement on this form (1) were bought for personal use by the patient listed above, (2) were not bought for employment purposes, (3) have not been and will not be reimbursed by another source, and (4) are not for resale. Place of Purchase: Place of Purchase: Date Purchased: Place of Purchased: Date Purchased:		First	Middle		Last		
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Please complete the remaining portion of this form: YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE (You must attach a copies of receipts in order for this form to be considered complete.) Place of Purchase: Date Purchased: Place of Purchased: Date Purchased:	described hereon and authorize re I agree that any benefits payable h thereof shall be void. I further rep I certify that the OTC, at home COV	elease of all inform tereunder for OTC, tresent that there b (ID-19 test(s) that I	ation contained on this voucher to at-home COVID-19 self-tests are nas been no assignment of benefit am submitting for reimbursement	o MaxorPlus and the not assignable and the street is hereunder.	he underwriter. d that any assignment or attervere bought for personal use	empted assignment by the patient listed	
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Date Purchased: Date Purchased: Date Purchased:							
	Place of Purchase:		Place of Purchase:		Place of Purchase:		
NDC # on the Package: NDC # on the Package: NDC # on the Package:	Date Purchased:			Date Purchased:			
	NDC # on the Package:		NDC # on the Package:		NDC # on the Package:		
# of Packages Purchased: # of Packages Purchased: # of Packages Purchased:	# of Packages Purchased:		# of Packages Purchased:		# of Packages Purchased:		
Quantity of Tests per Package: Quantity of Tests per Package: Quantity of Tests per Package:	Quantity of Tests per Package:		Quantity of Tests per Package:		Quantity of Tests per Package:		
Price Paid per Package: Price Paid per Package: Price Paid per Package:	Price Paid per Package:		Price Paid per Package:		Price Paid per Package:		
Brand Name: Brand Name: Brand Name:	Brand Name: Brand Name: Brand Name:						



MaxorPlus Over-the-Counter (OTC), At-Home COVID Test Reimbursement Form

Please Read Carefully Before Completing This Form

Use this claim form to request reimbursement for OTC, at-home COVID-19 tests purchased:

When filling out claim forms:

- * Complete a separate form for each family member for whom OTC, at-home COVID-19 tests were purchased.
- * Complete the top portion of the form in full. Incomplete forms will be returned to you for completing.
- * Include these numbers from your prescription card:
 - > Plan member's (insured) ID number
 - > Patient code: two-digit number assigned to individual family member (listed on card)
- * Include a copy of your receipt.

If you have any questions, please call: MaxorPlus Customer Service at (800) 687-0707.



FOLD WITH ADDRESS ON OUTSIDE, AFFIX POSTAGE AND MAIL

Patient Reimbursement Claims

MAXORPLUS

320 S. Polk, Suite 200 Amarillo, Texas 79101